Health Services
LOS ANGELES COUNTY

May 1, 2007

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To improve health through leadership, service and education.

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The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

PUBLIC-PRIVATE PARTNERSHIP PROGRAM AGREEMENT AMENDMENTS
(All Districts) (3 Votes)

IT IS RECOMMENDED THAT YOUR BOARD:

Delegate authority to the Director of the Department of Health Services (DHS or Department), or his designee, upon review and approval by County Counsel and Chief Administrative Office, to:

1. Amend 20 Public-Private Partnership (PPP) Program Health Care Services Agreements, substantially similar to Exhibit I, with those partners that have requested and met the requirements to participate in the Diabetes Care Management Pilot Project listed on Attachment B, to: 1) add a Diabetes Care Management Pilot Project component that will determine the feasibility of implementing a new payment methodology that will promote quality of care and improved health status, as well as a more cost effective utilization of resources; 2) include provisions to ensure contractual compliance and ability to impose liquidated damages as it relates to the Pilot Project; and 3) increase the total maximum obligation by $425,000, from $39,839,435 to $40,264,435, effective upon Board approval through October 30, 2008.

2. Amend 51 PPP Program Health Care Services Agreements, substantially similar to Exhibit II, with those agencies listed on Attachment B and B-1, to extend the term for primary, dental and specialty care services on a month-to-month basis for an additional three (3) months, to allow for the completion of a competitive bid process, effective July 1, 2007 through September 30, 2007, under the same rates and terms, in the amount of $13,480,689.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS:

In approving these actions, the Board is authorizing PPP Health Services Agreement Amendments to: 1) add the Diabetes Care Management Pilot

Project (Pilot Project) component to those twenty providers that met the program requirements and have requested to participate in the Pilot Project; and 2) extend the current Agreements month-to-month for an additional three (3) months to allow the Department to complete the current Request For Proposals (RFP) solicitation process for all PPP services (primary, dental and specialty care health).

The Pilot Project will allow for the implementation of a new payment methodology that will focus on health outcomes and sound disease management. The Pilot Project will be evaluated at the end of an 18-month period to determine if the results of the new payment methodology promotes good care management and improved health care, as well as a more cost effective utilization of resources.

The additional three (3) month extension is necessary to avoid any lapse in services while the RFP for all PPP services is completed.

FISCAL IMPACT/FINANCING:

The total cost for the Pilot Project is $425,000 increasing the maximum obligation from $39,839,435 to $40,264,435. The total cost for the three (3) month-to-month extension in Fiscal Year 2007-08 is $13,480,689.

Funding is included in the Department's Fiscal Year (FY) 2006-07 Final Budget and has been requested in the FY 2007-08 Proposed Budget Request.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS:

Background

A major goal of the 1115 Waiver was to expand access to primary care services to the medically indigent and uninsured. Prior to the 1115 Waiver, the Departments' health care delivery system emphasized inpatient care over comprehensive primary care or outpatient specialty services. Outpatient visits delivered by DHS were typically single purpose and disease-related, and not representative of client-centered comprehensive primary care. Even after the Waiver's implementation, expanded access was measured by counting the number of face-to-face visits delivered by licensed providers at DHS and PPP sites. PPPs continue to be reimbursed at an all-inclusive rate for those visits that meet the primary care visit definition established under the Waiver. While counting and paying for visits allows for a straightforward measure of access, it encourages provider-centered visits over more cost-effective, and sometimes more desirable types of care, not counted or reimbursed under the Waiver (e.g., group visits and telephonic contacts). Additionally, the reimbursement method does not focus on the quality of care or improved health status of patients served under the program.

With the expiration of the 1115 Waiver on June 30, 2005, the Department is no longer bound by the Waiver requirements and now has the flexibility to develop other measures of access and success, including other reimbursement methods that do not rely entirely on the provision of a face-to-face visit with a licensed health care provider. To explore different payment and programmatic options that focus more on quality of care and improved health status than on counting visits, a PPP Leadership Group with members representing the Community Clinic Association of Los Angeles County (CCALAC), PPP Strategic Partners and DHS was convened in December 2004. In addition, a Primary Care Subgroup, consisting mainly of DHS and PPP clinicians, was established to advise the Leadership Group on clinical issues.

After exploring different possible reimbursement options, the Leadership Group recommended a Pilot Project be undertaken and evaluated before initiating any substantive changes to either the existing program or payment structure. Given that six out of every ten PPP visits are for patients with one or more chronic conditions, it was further recommended that the Pilot Project focus on chronic rather than episodic care, and that it build upon the disease management infrastructure previously supported and funded by the Department and already in place at many PPP agencies. As such, the Leadership Group decided that, as a first step, the Pilot Project should focus on diabetes, since many PPP partners already have established diabetes management programs and electronic diabetes registries.

Diabetes Care Management Pilot Project

In January 2006, the Department released a Request to Participate (RTP) soliciting participation in the Pilot Project from existing PPP Program contractors who met the specific requirements in the RTP. As a result of the RTP, twenty PPP Program contractors requested to participate in the Pilot Project and met specific requirements.

The overall goal of the Pilot Project is to test the feasibility of implementing a new payment methodology focused on health outcomes and sound disease management principles for an acutely ill cohort of diabetic patients. Disease management programs have been demonstrated to improve both the quality and longevity of a patient's life while reducing incentives to over-schedule visits. The reimbursement methodology will be evaluated to determine whether it promotes good care management and improved health outcomes, as well as more cost-effective resource utilization. Based upon the results of the Pilot Project, DHS will evaluate the feasibility of expanding the "piloted" payment methodology to all high-risk PPP diabetic patients. The long-term goal is to integrate PPP primary care disease management activities fully with those currently being developed through the Department's Countywide Disease Management Program

Under the Pilot Project, the Department will randomly assign the Contractors to one of two groups: 1) Intervention Group, who will implement the new payment methodology and be reimbursed at the rate of $470 per calendar quarter for billable contacts; and 2) Control Group, who will continue to be reimbursed at the rate of $94 for a billable visit as described in the service agreement. To ensure compliance, there are provisions in the agreement that will allow for

liquidated damages should the Contractor fail to perform its contractual obligation as it relates to the Pilot Project.

The Pilot Project will take place over an 18-month period. However, because the Department is currently processing an RFP for all PPP Program services (primary, dental and specialty care health), only those Pilot Project participants who are successful in the solicitation process will continue in the Pilot Project.

Agreement Extensions - Three Months

The PPP Program provides the indigent, low-income, uninsured patient population with medical services throughout Los Angeles County at County and private facility sites. Patients must be at or below 133 1/3% of the Federal Poverty Level based on the Certification of Indigency (COI) as self-verification of income, or determined to be eligible General Relief recipients of the County.

On May 31, 2005, the Board approved 55 PPP Program Health Care Services Agreements, effective July 1, 2005 through June 30, 2006, with the provision to extend the term for an additional twelve months, as necessary. On May 11, 2006, the Department extended the current PPP Program Health Care Services Agreement for an additional twelve months through June 30, 2007, under the same terms and conditions.

The Department is currently in the final stages of completing an RFP solicitation process and expects to complete the process before September 2007. The additional three months will provide the necessary time frame for completion.

Attachments A, B, and B-1 provide additional information.

County Counsel has reviewed and approved Exhibits I and II, as to use and form.

CONTRACTING PROCESS:

It is not appropriate to advertise amendment contract actions on the Los Angeles County Online Website.

IMPACT ON CURRENT SERVICES (OR PROJECTS):

The Board's approval of the recommendation will allow the Department to implement and evaluate the outcomes of the Pilot Project to determine the feasibility of implementing a new payment methodology focusing on health outcomes and sound disease management and to extend the current PPP Agreements to avoid any lapse in services while the current RFP is finalized.

When approved, this Department requires three signed copies of the Board's action.

Respectfully submitted,

Bruce A. Chernof, M.D.
Director and Chief Medical Officer

BAC:lvb
PPP Diabetic.LVB.wpd

Attachments (5)

c: Chief Administrator Officer
County Counsel
Executive Officer, Board of Supervisors

ATTACHMENT A

SUMMARY OF AMENDMENTS

1. TYPE OF SERVICES:

   Pubic-Private Partnership Program (PPP) Health Care Services for the indigent, low-income, and uninsured patient population with primary, dental, and specialty care services throughout Los Angeles County and private facility sites and Diabetes Care Management Pilot Project (Pilot Project).

2. TERMS:

   The Amendments to add the Pilot Project will be effective upon Board approval through October 30, 2008.

   The Amendments to extend the current PPP Health Care Services Agreements will be effective July 1, 2007 through September 30, 2007.

3. AGENCY ADDRESSES AND CONTACT PERSONS:

   See Attachment B and B-1.

4. FINANCIAL INFORMATION:

   The total cost for the Pilot Project is $425,000 increasing the maximum obligation from $39,839,435 to $40,264,435. The total cost for the three (3) month-to-month extension is $13,480,689 in Fiscal Year 2007-08.

   Funding is included in the Department of Health Services' Fiscal Year (FY) 2006-07 Final Budget and has been requested in the FY 2007-08 Proposed Budget Request.

5. GEOGRAPHIC AREAS SERVED:

   All Supervisorial Districts

6. ACCOUNTABILITY FOR PROGRAM MONITORING AND EVALUATION:

   Wesley Ford, Director, Office of Ambulatory Care

7. APPROVALS:

Office of Ambulatory Care:	Wesley Ford, Director
Contracts and Grants:	Cara O'Neill, Chief
County Counsel (as to form):	Sharon A. Reichman, Principal Deputy

PUBLIC-PRIVATE PARTNERSHIP (PPP) PROGRAM AGREEMENTS
DIABETES PILOT PROJECT
CONTRACT INFORMATION AND REQUESTED ALLOCATION

	AGREEMENT NO.	AGENCY	CONTACT PERSON/ADDRESS/TELEPHONE/FAX	CURRENT ALLOCATION	REQUESTED ALLOCATION	REVISED ALLOCATION
1.	H701043	AltaMed Health Services, Corporation	Castulo de la Rocha, J.D., President and CEO 500 Citadel Drive, Suite 490 Los Angeles, CA 90040 Telephone: (323) 889-7835 Fax: (323) 889-7399	$1,892,183	$ 20,000	$1,912,183
2.	H701071	Central City Community Health Center	Carla Valenzuela, Chief Executive Director 5970 South Central Avenue Los Angeles, CA 90001 Telephone: (323) 724-0019 Fax: (323) 724-6915	$ 411,516	$ 20,000	$ 431,516
3.	H701075	Clinica Msr. Oscar Romero	Eduardo Gonzalez, Executive Director 123 South Alvarado Street Los Angeles, CA 90806 Telephone: (213) 201-2779 Fax: (213) 969-7702	$2,130,555	$ 20,000	$2,150,555
4.	H701050	Community Health Alliance of Pasadena	Margaret Miller, Executive Director 1855 North Fair Oaks Avenue, #200 Pasadena, CA 91103 Telephone: (626) 398-6300 Fax: (626) 398-5948	$1,135,404	$ 20,000	$1,155,404
5.	H701100	East Valley Community Health Center	Alicia M. Mardini, Chief Executive Officer 420 South Glendora Avenue West Covina, CA 91710 Telephone: (626) 919-4333 Ext. 220 Fax: (626) 919-2084	$2,645,971	$ 20,000	$2,665,971
6.	H701072	Eisner Pediatric and Family Medical Center	Carl E. Coan, President and CEO 1530 South Olive Street Los Angeles, CA 90015 Telephone: (213) 746-1037 Ext. 3330 Fax: (213) 746-9379	$1,956,746	$ 20,000	$1,976,746
7.	H701095	El Proyecto Del Barrio	Corrine Sanchez, Esq., President and CEO 8902 Woodman Avenue Arleta, CA 91331 Telephone: (818) 830-7133 Fax: (818) 830-7280	$1,912,981	$ 20,000	$1,932,981

PUBLIC-PRIVATE PARTNERSHIP (PPP) PROGRAM AGREEMENTS
DIABETES PILOT PROJECT
CONTRACT INFORMATION AND REQUESTED ALLOCATION

	AGREEMENT NO.	AGENCY	CONTACT PERSON/ADDRESS/TELEPHONE/FAX	CURRENT ALLOCATION	REQUESTED ALLOCATION	REVISED ALLOCATION
8.	H701089	Franciscan Clinics dba Queenscare Family Clinics	Terry Bonecutter, Chief Executive Officer 1300 North Vermont, #1002 Los Angeles, CA 90027 Telephone: (323) 953-7311 Fax: (323) 953-6244	$5,565,320	$ 20,000	$5,585,320
9.	H701092	Garfield Health Center	Frances Yu, M.D., President 210 Garfield Avenue, Suite 203 Monterey Park, CA 91754 Telephone: (626) 307-7397 Fax: (626) 307-1807	$ 565,246	$ 20,000	$ 585,246
10.	H701046	JWCH Institute, Inc.	Alvaro Ballesteros, Executive Director 1910 West Sunset Boulevard, Suite 650 Los Angeles, CA 90026 Telephone: (213) 484-1186 Ext. 3009 Fax: (213) 413-3443	$2,023,593	$ 20,000	$2,043,593
11.	H701098	Los Angeles Free Clinic	Jeff Bujer, Co-Chief Executive Officer 8405 Beverly Boulevard Los Angeles, CA 90048 Telephone: (323) 330-1660 Fax: (323) 658-6773	$4,077,456	$ 20,000	$4,097,456
12.	H701053	Mission City Community Network	Nick Gupta, Chief Executive Officer 15206 Parthenia Street North Hills, CA 91343 Telephone: (818) 895-3100 Ext. 602 Fax: (818) 892-4651	$ 924,220	$ 20,000	$ 944,220
13.	H701045	Northeast Community Clinic	Christopher Lau, M.D., Executive Director 2500 West Main Street, Suite 301 Alhambra, CA 91801 Telephone: (626) 457-6900 Fax: (626) 457-5022	$ 627,798	$ 20,000	$ 647,798
14.	H701076	Northeast Valley Health Corporation	Kimberly Ward, Chief Executive Officer 1172 North Maclay Avenue San Fernando, CA 91340 Telephone: (818) 898-1388 Fax: (818) 365-7670	$2,821,230	$ 20,000	$2,841,230

PUBLIC-PRIVATE PARTNERSHIP (PPP) PROGRAM AGREEMENTS
DIABETES PILOT PROJECT
CONTRACT INFORMATION AND REQUESTED ALLOCATION

	AGREEMENT NO.	AGENCY	CONTACT PERSON/ADDRESS/ TELEPHONE/FAX	CURRENT ALLOCATION	REQUESTED ALLOCATION	REVISED ALLOCATION
15.	H701055	South Bay Family Healthcare Center	Jan Hamilton Lee, President & CEO 23430 Hawthorne Boulevard, #210 Torrance, CA 90505 Telephone: (310) 802-6177 Fax: (310) 802-6178	$2,422,628	$ 20,000	$2,442,628
16.	H701077	South Central Family Health Center	Richard Veloz, President & CEO 4425 South Central Avenue Los Angeles, CA 90011 Telephone: (323) 908-4247 Fax: (323) 908-4262	$ 896,980	$ 20,000	$ 916,980
17.	H701146	St. John's Well Child Center	James J. Mangia, Executive Director 3800 South Figueroa Street Los Angeles, CA 90037 Telephone: (323) 541-1600 Ext. 4000 Fax: (323) 541-1661	$ 893,443	$ 20,000	$ 913,443
18.	H701056	Tarzana Treatment Center	Albert M. Senella, Chief Executive Officer 18646 Oxnard Street Tarzana, CA 91356 Telephone: (818) 996-1051 Ext. 1124 Fax: (818) 996-3051	$1,562,283	$ 20,000	$1,582,283
19.	H701086	The Children's Clinic	Elisa Nicholas, Executive Director 2801 Atlantic Avenue Long Beach, CA 90801 Telephone: (562) 933-0430 Fax: (562) 933-0415	$1,464,397	$ 20,000	$1,484,397
20.	H701078	Venice Family Clinic	Elizabeth Benson Forer, Chief Executive Officer 604 Rose Avenue Venice, CA 90291 Telephone: (310) 664-7901 Fax: 314-7641	$3,909,485	$ 45,000*	$3,954,485

* Venice Family Clinic will be providing additional data reporting.

PUBLIC-PRIVATE PARTNERSHIP (PPP) PROGRAM
CONTACT INFORMATION AND FUNDING REQUESTS
AMENDMENTS FISCAL YEAR 2007- 2008

	AGREEMENT NO.	AGENCY	CONTACT PERSON/ADDRESS/ TELEPHONE/FAX	7 MONTH ALLOCATION FY 07-08
1.	H701484	All For Health, Health for All, Inc	Noobar Jandian, M.D., Chief Medical Director 519 East Broadway Boulevard Glendale, CA 91205 Phone: 818-409-3020 Fax: 818-243-2713	$ 334,301
2.	H701043	AltaMed Health Services, Corporation	Castulo de la Rocha, J.D., President and CEO 500 Citadel Drive, Suite 490 Los Angeles, CA 90040 Telephone: (323) 889-7835 Fax: (323) 889-7399	$ 473,046
3.	H701048	Arroyo Vista Family Health Foundation	Lorraine Estradas, Chief Executive Officer 6000 North Figueroa Street Los Angeles, CA 90042 Phone: 323-254-5291 Fax: 323-254-4618	$ 340,754
4.	H701101	Asian Pacific Health Care Venture	Kazue Shibata, Executive Director 1530 Hillhurst Avenue, #200 Los Angeles, CA 90027 Phone: 323-644-3880 ext. 254 Fax: 323-644-3892	$ 282,071
5.	H701097	Avalon Medical Development Corporation dba Catalina Island Medical Center	William Green, Chief Executive Officer 100 Falls Canyon Road PO Box 1563 Avalon, CA 90704 Phone: 310-510-0700 Fax: 310-510-2381	$ 13,122
6.	H701084	BAART Community Healthcare	Jason Kletter, President 1111 Market Street, 4th Floor San Francisco, CA 94103 Phone: 415-552-7914 ext. 113 Fax: 415-552-3455	$ 294,195
7.	H701070	Bienvenidos Children's Center	Barbara Kappos, Director 205 East Palm Street Altadena, CA 91001 Phone: 626-798-7222 Fax: 626-798-8444	$ 55,941

PUBLIC-PRIVATE PARTNERSHIP (PPP) PROGRAM
CONTACT INFORMATION AND FUNDING REQUESTS
AMENDMENTS FISCAL YEAR 2007- 2008

	AGREEMENT NO.	AGENCY	CONTACT PERSON/ADDRESS/ TELEPHONE/FAX	3 MONTH ALLOCATION FY 07-08
8.	H701071	Central City Community Health Center	Carla Valenzuela, Chief Executive Director 5970 South Central Avenue Los Angeles, CA 90001 Telephone: (323) 724-0019 Fax: (323) 724-6915	$ 102,879
9.	H701135	Central Neighborhood Medical Group, Inc.	Bassett Brown, M.D., President 2707 South Central Avenue Los Angeles, CA 90011 Phone: 323-234-5000 Fax: 323-231-3985	$ 42,131
10.	H701049	Children's Dental Foundation	John L. Blake, DDS, Dental Director 455 East Columbia Street Long Beach, CA 90801 Phone: 562-933-2501 Fax: 933-2049	$ 177,962
11.	H701369	Chinatown Service Center	Lawrence J. Lue, Executive Director 767 North Hill Street, Suite 200 Los Angeles, CA 90012 Phone: 213-808-1740 ext. 310 Fax: 213-680-9427	$ 101,382
12.	H701075	Clinica Msr. Oscar Romero	Eduardo Gonzalez, Executive Director 123 South Alvarado Street Los Angeles, CA 90806 Telephone: (213) 201-2779 Fax: (213) 969-7702	$ 532,639
13.	H701050	Community Health Alliance of Pasadena	Margaret Miller, Executive Director 1855 North Fair Oaks Avenue, #200 Pasadena, CA 91103 Telephone: (626) 398-6300 Fax: (626) 398-5948	$ 283,861
14.	H701147	Compton Central Health Clinic, Inc.	Marie Lamothe, Executive Director 201 North Central Avenue Compton, CA 90220 Phone: 310-635-7123 Fax: 310-635-0535	$ 14,044

PUBLIC-PRIVATE PARTNERSHIP (PPP) PROGRAM
CONTACT INFORMATION AND FUNDING REQUESTS
AMENDMENTS FISCAL YEAR 2007- 2008

	AGREEMENT NO.	AGENCY	CONTACT PERSON/ADDRESS/ TELEPHONE/FAX	6 MONTH ALLOCATION 1/1/08 - 6/30/08
15.	H701073	Durfee Family Care Medical Group	Ishale Bishara, M.D., Medical Director 2006 Durfee Avenue El Monte, CA 91733 Phone: 626-442-5015 Fax: 626-442-7810	$ 70,307
16.	H701100	East Valley Community Health Center	Alicia M. Mardini, Chief Executive Officer 420 South Glendora Avenue West Covina, CA 91710 Telephone: (626) 919-4333 Ext. 220 Fax: (626) 919-2084	$ 661,493
17.	H701072	Eisner Pediatric and Family Medical Center	Carl E. Coan, President and CEO 1530 South Olive Street Los Angeles, CA 90015 Telephone: (213) 746-1037 Ext. 3330 Fax: (213) 746-9379	$ 489,186
18.	H701085	El Dorado Community Service Center	Stan Sharma, Executive Director PO Box 801809 Valencia, CA 91380 Phone: 310-671-0555 Fax:310-674-5292	$ 95,766
19.	H701095	El Proyecto Del Barrio	Corrine Sanchez, Esq., President and CEO 8902 Woodman Avenue Arleta, CA 91331 Telephone: (818) 830-7133 Fax: (818) 830-7280	$ 478,245
20.	H701074	Family Health Care Centers of Greater Los Angeles	Raquel Villa, Chief Executive Officer 6501 South Garfield Avenue Bell Gardens, CA 90201 Phone: 818-830-7133 Fax: 818-830-7280	$ 187,922
21.	H701089	Franciscan Clinics dba Queenscare Family Clinics	Terry Bonecutter, Chief Executive Officer 1300 North Vermont, #1002 Los Angeles, CA 90027 Telephone: (323) 953-7311 Fax: (323) 953-6244	$1,391,330

PUBLIC-PRIVATE PARTNERSHIP (PPP) PROGRAM
CONTACT INFORMATION AND FUNDING REQUESTS
AMENDMENTS FISCAL YEAR 2007- 2008

	AGREEMENT NO.	AGENCY	CONTACT PERSON/ADDRESS/ TELEPHONE/FAX	3 MONTH ALLOCATION FY 07-08
22.	H701092	Garfield Health Center	Frances Yu, M.D., President 210 Garfield Avenue, Suite 203 Monterey Park, CA 91754 Telephone: (626) 307-7397 Fax: (626) 307-1807	$ 141,311
23.	H701909	Harbor Community Clinic (formerly known as Harbor Free Clinic)	Michele Ruple, Executive Director 593 West 6th Street San Pedro, CA 90731 Phone: 310-547-0202 Fax: 310-547-5096	$ 112,350
24.	H701046	JWCH Institute, Inc.	Alvaro Ballesteros, Executive Director 1910 West Sunset Boulevard, Suite 650 Los Angeles, CA 90026 Telephone: (213) 484-1186 Ext. 3009 Fax: (213) 413-3443	$ 505,898
25.	H701047	Korean Health, Education, Information and Research Center	Erin Pak, Chief Executive Officer 3727 West 6th Street, Suite 210 Los Angeles, CA 90020 Phone: 213-427-4000 Fax: 213-368-6047	$ 20,088
26.	H701088	Koryo Health Foundation Community Clinic	Kyeog Hwan Seo, M.D., Chief Medical Director 1058 South Vermont Avenue Los Angeles, CA 90006 Phone: 213-380-8833 ext 108 Fax: 213-368-6047	$ 24,276
27.	H701098	Los Angeles Free Clinic	Jeff Bujer, Co-Chief Executive Officer 8405 Beverly Boulevard Los Angeles, CA 90048 Telephone: (323) 330-1660 Fax: (323) 658-6773	$1,019,363
28.	H701053	Mission City Community Network	Nick Gupta, Chief Executive Officer 15206 Parthenia Street North Hills, CA 91343 Telephone: (818) 895-3100 Ext. 602 Fax: (818) 892-4651	$ 231,054

PUBLIC-PRIVATE PARTNERSHIP (PPP) PROGRAM
CONTACT INFORMATION AND FUNDING REQUESTS
AMENDMENTS FISCAL YEAR 2007- 2008

	AGREEMENT NO.	AGENCY	CONTACT PERSON/ADDRESS/ TELEPHONE/FAX	5 MONTH ALLOCATION FY 07-08
29	H701045	Northeast Community Clinic	Christopher Lau, M.D., Executive Director 2500 West Main Street, Suite 301 Alhambra, CA 91801 Telephone: (626) 457-6900 Fax: (626) 457-5022	$ 137,068
30.	H701134	Northeast Community Clinic	Christopher Lau, M.D., Executive Director 2500 West Main Street, Suite 301 Alhambra, CA 91801 Telephone: (626) 457-6900 Fax: (626) 457-5022	$ 156,950
31.	H701076	Northeast Valley Health Corporation	Kimberly Ward, Chief Executive Officer 1172 North Maclay Avenue San Fernando, CA 91340 Telephone: (818) 898-1388 Fax: (818) 365-7670	$ 705,307
32.	H701175	Pomona Valley Hospital Medical Center	Julie Wilson, Vice President 1798 North Garey Avenue Pomona, CA 91767 Phone: 909-964-6542 Fax: 909-865-9796	$ 195,162
33.	H701069	Sacred Heart Family Medical Clinics, Inc.	Eduardo S. Ornedo, M.D., President 8540 Alondra Boulevard Paramount, CA 90723 Phone: 562-602-2508 Fax: 562-602-2382	$ 14,044
34.	H701080	Samuel Dixon Family Health Center	Cheryl Laymon, Executive Director 30257 San Martinez Road Val Verde, CA 91384 Phone: 661-257-7892 Fax: 661-257-2384	$ 14,044
35.	H701094	South Atlantic Medical Group	Nissan Kahen, M.D., President & CEO 5504 Whittier Boulevard Los Angeles, CA 90022 Phone: 323-725-0167 Fax: 323-725-6933	$ 28,087

PUBLIC-PRIVATE PARTNERSHIP (PPP) PROGRAM
CONTACT INFORMATION AND FUNDING REQUESTS
AMENDMENTS FISCAL YEAR 2007- 2008

	AGREEMENT NO.	AGENCY	CONTACT PERSON/ADDRESS/ TELEPHONE/FAX	3 MONTH ALLOCATION FY 07-08
36.	H701055	South Bay Family Healthcare Center	Jan Hamilton Lee, President & CEO 23430 Hawthorne Boulevard, #210 Torrance, CA 90505 Telephone: (310) 802-6177 Fax: (310) 802-6178	$ 605,657
37.	H701077	South Central Family Health Center	Richard Veloz, President & CEO 4425 South Central Avenue Los Angeles, CA 90011 Telephone: (323) 908-4247 Fax: (323) 908-4262	$ 224,245
38.	H701146	St. John's Well Child and Family Center, Inc.	James J. Mangia, Executive Director 3800 South Figueroa Street Los Angeles, CA 90037 Telephone: (323) 541-1600 Ext. 4000 Fax: (323) 541-1661	$ 223,361
39.	H701054	T.H.E. Clinic, Inc.	Jai Henderson, Chief Executive Director 3834 South Western Avenue Los Angeles, CA 90062 Phone: 323-730-1920 Ext. 3007 Fax: 323-730-9777	$ 126,671
40.	H701056	Tarzana Treatment Center	Albert M. Senella, Chief Executive Officer 18646 Oxnard Street Tarzana, CA 91356 Telephone: (818) 996-1051 Ext. 1124 Fax: (818) 996-3051	$ 390,571
41.	H701086	The Children's Clinic	Elisa Nicholas, Executive Director 2801 Atlantic Avenue Long Beach, CA 90801 Telephone: (562) 933-0430 Fax: (562) 933-0415	$ 366,099
42.	H701083	The Church of Our Saviour	Doris Dann 4368 Santa Anita Avenue El Monte, CA 91731 Phone: 626-579-0290 Ext. 121 Fax: 626-579-2689	$ 28,088

PUBLIC-PRIVATE PARTNERSHIP (PPP) PROGRAM
CONTACT INFORMATION AND FUNDING REQUESTS
AMENDMENTS FISCAL YEAR 2007- 2008

	AGREEMENT NO	AGENCY	CONTACT PERSON/ADDRESS/ TELEPHONE/FAX	3 MONTH ALLOCATION FY 07-08
43.	H701090	Universal Health Foundation	Syed K. Multani, M.D., President & CEO 2020 East First Street Los Angeles, CA 90033 Phone: 323-980-9600 Fax: 323-980-9676	$ 8,426
44.	H701898	University Muslim Medical Association, Inc.	Yasser Aman, President & CEO 711 West Florence Avenue Los Angeles, CA 90044 Phone: 323-967-0375 Fax: 323-789-5616	$ 67,410
45.	H701149	Valley Community Clinic	Paula Wilson, President & CEO 6801 Coldwater Canyon North Hollywood, CA 91605 Phone: 818-763-1718 Ext. 204 Fax: 818-763-7231	$ 334,750
46.	H701078	Venice Family Clinic	Elizabeth Benson Forer, Chief Executive Officer 604 Rose Avenue Venice, CA 90291 Telephone: (310) 664-7901 Fax: 314-7641	$ 977,371
47.	H701051	Visiting Nurse Community Services	James A. Cook, Executive Director 732 Mott Street, Suite 150 San Fernando, CA 91340 Phone: 818-837-3775 Fax: 818-837-3799	$ 10,458
48.	H701136	Watts Healthcare Corporation	William Hobson, President & CEO 10300 Compton Avenue Los Angeles, CA 90002 Phone: 323-568-4417 Fax: 323-563-6378	$ 89,351
49.	H701051	Westside Family Health Center	Debra A. Farmer, Chief Executive Officer 1711 Ocean Park Boulevard Santa Monica, CA 90405 Phone: 310-450-4773-Ext. 222 Fax: 310-450-0873	$ 87,089

PUBLIC-PRIVATE PARTNERSHIP (PPP) PROGRAM
CONTACT INFORMATION AND FUNDING REQUESTS
AMENDMENTS FISCAL YEAR 2007- 2008

	AGREEMENT NO	AGENCY	CONTACT PERSON/ADDRESS/ TELEPHONE/FAX	3 MONTH ALLOCATION FY 07-08
50.	H701051	Westside Neighborhood Clinic	Alan Terwey, Executive Director 2125 Santa Fe Avenue Long Beach, CA 90810 Phone: 562-432-9575 Fax: 562-432-9590	$ 101,213
51.	H701093	Wilmington Community Clinic	Dolores Bonilla Clay, Chief Executive Officer 1009 North Avalon Boulevard Wilmington, CA 90744 Phone: 310-549-9713 Ext. 102 Fax: 310-549-2277	$ 112,350

EXHIBIT I

Contract # _____

PUBLIC/PRIVATE PARTNERSHIP PROGRAM
HEALTH CARE SERVICES AGREEMENT
(_____ Partner Facility Sites)

AMENDMENT NO. ___

THIS AMENDMENT is made and entered into this _____ day of _____, 2007,

by and between COUNTY OF LOS ANGELES (hereafter "County"),

and _____ (hereafter "Contractor").

WHEREAS, reference is made to that certain document entitled "PUBLIC/PRIVATE PARTNERSHIP PROGRAM HEALTH CARE SERVICES AGREEMENT", dated _____, further identified as Agreement No. _____ and any amendments thereto (all hereafter "Agreement"); and

WHEREAS, Contractor responded to the County's 2006 PPP Program Request to Participate which solicited existing PPP Program Contractors to participate in a Diabetes Care Management Pilot Project to test the feasibility of implementing a new payment methodology focused on health outcomes and sound disease management principles for an acutely ill cohort of diabetic patients; and

WHEREAS, Contractor was selected to participate in the PPP Program Diabetes Care Management Pilot Project as a result of the PPP Program's 2006 Request to Participate; and

WHEREAS, Contractor has a history of commitment to diabetes care management, is willing and able to collect and report data required under the Pilot Project through an electronic disease registry that the Contractor uses to manage the care of their diabetic patients, and has a least two years of experience implementing the Chronic Care Model of disease management; and

WHEREAS, Contractor has demonstrated the availability and commitment of its chronic care leadership team to the Pilot Project and has assigned a responsible team leader to the Pilot Project; and

WHEREAS, Contractor agrees to provide services regardless of the demonstration group (i.e., Intervention or Control Group) to which Contractor will be assigned after execution of this Agreement; and

WHEREAS, the Agreement provides that changes to its terms may be made in the form of a written amendment which is formally approved and executed by the parties.

NOW, THEREFORE, the parties hereby agree as follows:

1. This Amendment shall be effective upon its approval by County's Board of Supervisors.

2. Agreement, Paragraph 2, MAXIMUM OBLIGATION, Subparagraph B, shall be revised as follows:

"2. MAXIMUM OBLIGATION:

B. County's reimbursement to Contractor for Fiscal Year 2006-07 shall not exceed _____ Dollars ($_____). That portion of the maximum obligation shall be _____ Dollars ($_____) for the provision of primary care services; and _____ Dollars ($_____) for the provision of dental care services; and _____ Dollars ($_____) for the provision of specialty care services.

Effective upon date of Board approval through October 30, 2008, County's reimbursement to Contractor for Diabetes Care Management Pilot Project services shall not exceed _____ Dollars ($_____). This allocation may not be redirected to any other services provided under this Agreement and shall be utilized over the entire term of the Diabetes Care Management Pilot Project."

These portions of the maximum obligation may be changed, with the exception of funds allocated to the Diabetes Care Management Pilot Project, if there is a reallocation to or from other County contract service providers under the County's PPP Program for primary

care in accordance with the FUNDING REALLOCATION OF COUNTY'S FISCAL YEAR MAXIMUM OBLIGATION UNDER THIS AGREEMENT AND OTHER PPP PROGRAM CONTRACTS Paragraph of this Agreement."

3. Exhibit ____, DIABETES CARE MANAGEMENT PILOT PROJECT, and Exhibit ___Attachments I through VI, all attached hereto and incorporated by reference, are hereby added to Agreement.

4. Except for the changes set forth hereinabove, Agreement shall not be changed in any other respect by this Amendment.

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Agreement to be subscribed by its

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Director of Health Services, and Contractor has caused this Agreement to be subscribed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By_____

Bruce A. Chernof, M.D.
Director and Chief Medical Officer

_____
Contractor

By _____
Signature

_____
Printed Name

Title _____

(AFFIX CORPORATE SEAL)

APPROVED AS TO FORM
BY THE OFFICE OF THE COUNTY COUNSEL

APPROVED AS TO CONTRACT
ADMINISTRATION:

Department of Health Services

By_____
Cara O'Neill, Chief
Contracts and Grants Division

4703_ExhI 040207

EXHIBIT __

DIABETES CARE MANAGEMENT PILOT PROJECT

1. DIABETES CARE MANAGEMENT PILOT PROJECT SERVICES: Contractor shall be responsible for providing diabetes care management services to a cohort of Eligible Pilot Patients, which shall hereafter be referred to as "Pilot Patients". For purposes of this Agreement, "diabetes care management services" means services to those diabetic patients who are eligible for and enrolled in Contractor's Diabetes Care Management Pilot Project,(Pilot Project) which is intended to improve the Pilot Patients' diabetic condition and clinical outcomes by implementing the Chronic Care Model attached hereto and incorporated herein as Attachment I.

2. CONTRACTOR DEMONSTRATION GROUP SELECTION AND ASSIGNMENT: Prior to implementation of the "Pilot Project", County shall facilitate a meeting at which Contractor shall be randomly placed into either the "Intervention" or "Control" demonstration group. The description and requirements of each demonstration group are defined below. Contractor hereby agrees to provide Pilot Project services regardless of the demonstration group to which Contractor is assigned. Contractor shall be assigned to the _____ Group.

3. PILOT PROJECT DEMONSTRATION GROUP DESCRIPTION: Contractors assigned in either group shall adhere to the group requirements as described in Sub-paragraph A or B, as applicable.

Only the reimbursement methodology shall define the two groups, as described below.

A. Intervention Group: The Intervention Group shall be defined as that group of Pilot Project Contractors implementing the new payment methodology, which shall be Four Hundred Seventy Dollars ($470.00) per calendar quarter for billable contacts as described in the Claims Reimbursement paragraph of this Exhibit.

B. Control Group: The Control Group shall be defined as that group of Pilot Project Contractors continuing to receive payment for services via the current payment reimbursement methodology which is Ninety-Four Dollars ($94.00) per billable visit as described in the Claims Reimbursement paragraph of this Exhibit.

4. PATIENT ELIGIBILITY: Contractor shall verify and document patient eligibility for Pilot Project services under this Agreement in accordance with the ELIGIBILITY Paragraph of the body of this Agreement. Verification of patient's Los Angeles County residency, income and insurance status must be documented in the patient's medical record through the inclusion of a completed, signed, and dated Certification of Indigency (COI). In addition, verification of patient's diabetes risk status must be documented in the patient's medical record through the inclusion of the completed, signed, and dated Diabetes Risk Stratification Worksheet ("Worksheet"), attached hereto and

incorporated herein by reference as Attachment II. All such documentation must be maintained in accordance with the RECORDS AND AUDITS Paragraph of the ADDITIONAL PROVISIONS. Only those patients who meet these eligibility requirements shall be considered Eligible Pilot Patients and therefore eligible for reimbursement under this Agreement.

5. PATIENT ENROLLMENT: Only Eligible Pilot Patients may be "enrolled" into Contractor's Pilot Project cohort of patients. For purposes of this Agreement, "enrollment" in the Pilot Project is established once Contractor has 1) determined it has capacity within its Pilot Project cohort; and 2) obtained Eligible Pilot Patient's signature on the Patient Participation Agreement, attached hereto and incorporated herein by reference as Attachment III. A patient is not considered enrolled until these two (2) criteria are met.

By the 30th of each month, Contractor shall submit to County: 1) a copy of each newly enrolled Eligible Pilot Patient's Patient Participation Agreement; and 2) an updated Enrollment Log, which shall provide County with a complete list of all enrolled Eligible Pilot Patients. Upon full execution of this Agreement, County shall provide Contractor with the Enrollment Log via the Provider Information Notice (PIN) process.

6. PILOT PROJECT FACILITY SITE(S): Contractor shall provide services at the facility sites set forth in Attachment V, Contractor's Approved Pilot Project Facility Site(s). Contractor

shall inform Director in writing at least forty-five (45) calendar days prior to adding, closing, or relocating a site, for provision of Pilot Project services hereunder. The addition, deletion or relocation of a facility site may be affected only after obtaining the Director's written approval. Those facility sites included in Contractor's Workplan, as attached to Exhibit A of this Agreement, are considered authorized and approved Pilot Project Facility Sites. Any changes to Attachment V must have the prior written consent of the Director.

7. CONTRACTOR'S OBLIGATIONS: Contractor shall be responsible for the following:

A. Operations:

1. Diabetes Care Management Team: Within thirty (30) days from execution of this Agreement, Contractor shall notify County of Contractor's Pilot Project Team, including Project Team Leader using County's approved form. Upon full execution of this Agreement, County shall provide Contractor with the approved form via the PIN process as described in the body of this Agreement. Contractor shall provide advance written notice to County of any changes to its Diabetes Care Management Team at least fifteen (15) days in advance of any change.

2. Meeting Participation: Contractor shall be required to attend all quarterly meetings as scheduled

and facilitated by County, in addition to any ad hoc meetings that may be convened throughout the term of the Pilot Project. County shall distribute the schedule of quarterly meetings upon full execution of this Agreement.

In addition, Contractor shall regularly attend and participate in County's Implementation Team meetings jointly facilitated with the Community Clinic Association of Los Angeles County's (CCALAC) Clinical Advisory Group, which shall oversee and guide implementation of the Chronic Care Model process. For the purpose of this Pilot Project Contractor is not required to be a CCALAC member to attend these meetings. County shall distribute the schedule of the Implementation Team meetings upon execution of this Agreement.

3. Data Management and Reporting: Contractor shall maintain an electronic disease registry using a registry system approved by County. Upon completion of any service to an enrolled Pilot Patient, Contractor shall enter all applicable information into Contractor's electronic disease registry. All data fields included in the Patient Electronic Care System (PECS) Data Dictionary attached hereto and incorporated

herein by reference as Attachment IV must be completed for all enrolled Pilot Patients.

Upon full execution of this Agreement, Contractor shall establish a Business Associates Agreement with County's Data Warehouse Contractor following the guidelines established by County and provided to Contractor via the PIN process.

B. Project Management: Contractor must manage Pilot Project financial resources to ensure that there are sufficient funds over the term of this Pilot Project to provide continuous care, as medically appropriate, to Eligible Pilot Patients. Medically necessary follow-up care and medications must be provided without charge to Eligible Pilot Patients as long as he/she meets the Public Private Partnership (PPP) Program financial eligibility criteria.

C. Performance Measurement:

1. Electronic Data Reporting: Contractor shall electronically transfer all data registry information for all enrolled Pilot Project Patients to County's Data Warehouse Contractor as directed. Contractor shall adhere to the data transfer guidelines contained in the Data Report Transmission Paragraph of this Exhibit, or as set forth by County via the PIN process. County shall provide Contractor the electronic address for

such data transfers prior to the commencement of Pilot Project services hereunder through the PIN process.

a. Data Report Transmissions: Contractor shall electronically transmit the electronic disease registry data for all enrolled Pilot Patients to County's Data Warehouse Contractor as directed by County through the PIN process. These transmissions shall report information collected in all data fields as described in the PECS Data Dictionary, Attachment IV.

b. Patient Satisfaction Surveys: During the term of this Pilot Project, Contractor shall conduct Patient Satisfaction Surveys of enrolled Pilot Project Patients on a quarterly basis. County shall provide the Patient Satisfaction Survey form(s) and implementation instructions to Contractor in advance of this requirement via the PIN process.

c. Chronic Care Model Assessment: At six (6) month intervals during the term of this Pilot Project, Contractor shall complete and submit to County the Chronic Care Model Assessment, Attachment VI. County shall provide instructions to Contractor via the PIN process and through the

CCALAC Clinical Advisory Group meetings as described above.

d. Provider Interviews: During the term of this Pilot Project, County's Pilot Project Evaluation Team shall conduct on-site provider interviews to gather information for the evaluation of the outcomes of the Pilot Project. County shall conduct one to four (1-4) on-site evaluation interviews with Contractor's diabetes care management team. The number of on-site interviews shall be dependent upon to which demonstration group Contractor is assigned (i.e., Intervention or Control). County and Contractor will schedule the interviews at a mutually agreeable time.

8. CLAIMS REIMBURSEMENT: County shall reimburse Contractor for Pilot Project services provided only to Eligible Pilot Patients at facility sites approved by County and included in Contractor's Approved Pilot Project Facility Site(s), Attachment V. At no time shall County reimburse Contractor for services provided to an enrolled Pilot Patient at a facility site not included in Contractor's Approved Pilot Project Facility Sites, Attachment V.

A. Intervention Group: Contractors assigned to the "Intervention Group" as defined in this Agreement, shall be

reimbursed by County at the rate of Four Hundred Seventy Dollars ($470.00) for one (1) "billable contact" for each enrolled Pilot Patient per calendar quarter. For purposes of this Pilot Project, a billable contact shall be defined as any encounter between an Eligible Pilot Patient and Contractor team with the purpose of receiving Pilot Project services. In order to be reimbursed as a billable contact, such services shall be recorded in the Pilot Patient's medical record and appropriately entered into Contractor's electronic disease registry. No other diabetic services for enrolled Pilot Patients shall be reimbursed for that calendar quarter for which Contractor receives reimbursement under the Pilot Project payment methodology. County shall cancel any diabetic claims that have been reimbursed at a rate of Ninety-Four Dollars ($94.00) for any Eligible Pilot Patient within the calendar quarter for which a Pilot Project claim has been submitted and reimbursed.

B. Control Group: Contractors assigned to the "Control Group", as defined in Agreement shall be reimbursed by County at the rate of Ninety-Four Dollars ($94.00) for every "billable visit". For purposes of this Agreement, a "billable visit" shall be defined as a face-to-face encounter between a patient and a licensed, registered, or certified health care professional who exercises independent judgement in the provision of preventive, diagnostic, or

treatment services.

In order to be reimbursed as a "billable visit" under the Pilot Project, all health services, including ancillary services provided during or as a result of a visit, shall be recorded in the patient's medical record and appropriately entered into Contractor's electronic disease registry.

9. CLAIMS BILLING PROCESS: Contractor shall submit Pilot Project claims to County's claims adjudicator in accordance with the Billing and Payment paragraph of this Agreement. All Pilot Project claims shall be submitted using Current Procedural Terminology("CPT") code 99999 and one of the following International Classification of Diseases-9("ICD-9") codes as the primary diagnosis: 250-251.99, V58.57, 648, 648.0, or 648.8. Only those claims that meet this criterion will be accepted.

A. Electronic Billings To County: Contractor shall submit to County's claims adjudicator data elements substantially similar to those found on the Federal Centers for Medicare and Medicaid Services ("CMS") Form 1500, Form UB-92, or other form approved by Director ("Billing Form").

Such data shall be submitted electronically for service to Eligible Patients monthly in arrears. None of Contractor's physicians or other providers shall separately bill County or Eligible Pilot Patients or their families for services hereunder.

B. Manual Billings to County: If electronic billing

between Contractor and County's claims adjudicator is not operational, Contractor shall utilize a manual Billing Form approved by County. Contractor shall submit a manual Billing Form to County's adjudicator in duplicate and shall retain one billing copy for its own records and forward the original billing copy to Director.

All manual billing shall be submitted separately from other claims made under this Agreement and shall clearly indicate that the billing is for services rendered under the Pilot Project. None of Contractor's physicians or other providers shall separately bill County or Eligible Pilot Patients or their families for services hereunder.

C. County's Manual Reprocessing Of Contractor's Denied Claims: If claims were denied through no fault of County or County's claims adjudicator, Contractor shall reimburse County the per claim fee billed to County by County's claims adjudicator in accordance with the fee specified in the Agreement. County shall notify Contractor of the current denied claim fee charged to County via the PIN process. County shall bill Contractor for denied claim reprocessing fees on a monthly basis, with payment due to County within thirty (30) calendar days of the date on County's invoice. If County does not receive payment in a timely manner, County may withhold such amount from the usual monthly payment for Contractor services under this

Agreement.

10. PERFORMANCE MEASUREMENT DATA REIMBURSEMENT: County shall reimburse Contractor not less than quarterly as follows for receipt of performance measurement data as described above:

A. Electronic Disease Registry Transmission, Patient Participation Agreement, Patient Satisfaction Surveys, and Chronic Care Model Assessment: A one-time only reimbursement of Eighty Dollars ($80.00) per enrolled Pilot Project patient.

B. On-Site Provider Interviews: Five Hundred Dollars ($500.00) per site visit.

County of Los Angeles – Department of Health Services
Office of Ambulatory Care (OAC)
Public-Private Partnership (PPP) Program

Diabetes Care Management Pilot Project
Chronic Care Model

The Chronic Care Model identifies six essential elements: community resources and policies, health care organization, self-management support, delivery system design, decision support, and clinical information systems. Each of the six elements are described briefly below and participating agencies will be required to implement them as part of their participation in the Pilot Project.

a) *Community resources and policies.* To improve chronic care, provider organizations need linkages with community-based resources, e.g., patient education classes, nutrition counseling, peer support groups, home care agencies and senior centers. Such linkages between the health delivery system (or provider practice) and relevant community resources are likely to play important roles in the management of chronic illness. Additionally, they are a cost-effective way to obtain needed services. Negotiations with other health care organizations in the community are also important to enhancing continuity of care and expand services or to gathering data useful to the registry. For example, community-based health centers can negotiate new relationships with neighboring hospitals or specialty groups to gain access to self-management classes or nurse educator services, or with their commercial laboratories to get downloads of laboratory data for their registries.

b) *Health care organization*: The structure, goals and values of a provider organization, and its relationships with purchasers, insurers and other providers, form the foundation upon which the remaining four components of the Chronic Care Model rest. Chronic illness programs are more likely to be effective if the overall system (organization) in which care is provided is oriented and led in a manner that allows for a focus on chronic illness care. If an organization's goals and leaders do not view chronic care as a priority, innovation will not take place. The visible support and promotion of chronic disease improvement programs by organization leaders has been shown to be a major predictor of success. Senior leaders are instrumental in securing resources or removing barriers that may stall quality improvement activities. Additionally, having chronic illness improvement represented in the organization's goals and business plan encourages senior leaders' involvement and support.

c) *Self-Management Support*: For chronic conditions (in contrast with acute illness), patients themselves are the primary caregivers. Because people live with a chronic illness for many years, because the management of the illness is often relatively simple, and because that management (diet, exercise, the taking of medications etc.) is under the control of the patient rather than of the health professional, a chronic condition is most successfully managed by the person living with the conditions. Self-management support involves teaching patients how to manage their chronic illness, providing tools for such

self-management (for example, blood pressure cuffs, e.g., glucometers, diets, and referrals to community resources). Effective self-management support can help patients and families cope with the challenges of living with and treating chronic illness and reduce complications and symptoms. They generally emphasize the patient's crucial role in maintaining health and function and the importance of setting goals, establishing action plans, identifying barriers, and solving problems to overcome barriers. Evidence indicates that collaborative goal setting, action planning, and problem solving should be integrated into routine care. Routine assessment of self-management practices and the inclusion of self-management practices and the inclusion of self-management goals in a registry have helped many organizations to keep attention focused on self-management.

d) *Delivery System Design*: The available evidence suggests that effective chronic illness management involves more than simply adding additional interventions to a current system focused on acute care. It may necessitate changes to the organization of practice that directly impact the day-to-day provision of care. Essential to success is the creation of a practice team with a clear division of labor based on planned and coordinated actions. Many of these actions can be efficiently and consistently carried out by non-professional personnel using defined protocols. However, increasing evidence supports the value of access to more sophisticated clinical case manager functions. Disease registry information can also be used to organize individual or group visits that are planned and focused. Additionally, increased telephone contact can be used to enhance patient follow-up.

e) *Decision Support*: Clinical information, based on evidence-based clinical practice guidelines, assists clinicians to provide the best care for chronically ill patients. This includes evidence-based practice guidelines or protocols, specialty consultation, provider education, and activating patients to make provider teams aware of effective therapies. Evidence shows that if the guidelines are not woven into the fabric of patient care they are not likely to change clinical practice in any significant way. Incorporating guidelines into the registry, flow sheets, and patient assessment tools will usually accomplish this, as

f) reports at the time of encounters that include reminders. The summary reports are particularly effective if they can also be used to serve as the visit medical record.

g) *Clinical Information Systems*: Computerized information can play three important roles in chronic illness management: 1) reminder systems that help primary care teams comply with evidence-based guidelines for chronic illnesses; 2) feedback to clinicians showing how each is performing on chronic illness markers such as Hemoglobin a1c, lipids and blood pressures for diabetic patients; 3) registries for population-based care. As such, timely, useful information about individual patients and populations of patients with chronic conditions is a critical feature of effective programs, especially those that employ population-based approaches. For example, the registry can sort and identify patients that have hemoglobin 1ac levels above 8.5 for follow-up. Creating the capability for a registry to produce treatment-planning reports that serve as the visit record has also proven to be a critical step in improving patient care.

EXHIBIT ___ ATTACHMENT II

Diabetes Risk Stratification Worksheet

Criteria	Value	Weight (TBD)	Total Points
HbA1c	14+ 13-13.9 12-12.9 11-11.9 10-10.9 9-9.9	__ point	HbA1c Points _____
	8-8.9 7-7.9 Below 7 Not Done	__ point	
LDL	200+ 160-199 130-159	__ point	LDL Points _____
	100-129 Less than 100 Not Done Not Calculable	__ point	
Co-morbidities	Dx Depression Dx Hypertension Nephropathy Retinopathy		Co-morbidities Points _____
SBP	More than 180 160-179 140-159	__ point	SBP Points _____
	121-139 120 or less	__ point	
DBP	More than 100 90-99	__ point	DBP Points _____
	85-89 81-84 80 or less	__ point	

Eligibility Score (sum of all points here): _____

EXHIBIT ___ ATTACHMENT III

DISEASE MANAGEMENT PROGRAM
DIABETES MELLITUS

PATIENT PARTICIPATION AGREEMENT

PLEASE READ AND SIGN

I, _____, agree to work with ***NAME OF CLINIC*** as an active partner in the management of my diabetes. I agree to participate in the management of my care, and to:

- Work with clinic staff
- Utilize the services that are offered to me
- Follow directions given to me
- Take my medications as prescribed
- Keep my appointments

I acknowledge that improving my health depends on my participation. Should I no longer receive the special services offered to me by this program, I will continue to receive other medical care provided by the clinic.

Together, ***NAME OF CLINIC*** and I will work to take control of my disease rather than allowing it to be in control.

_____ _____

(Patient's Signature) (Date/Time)

_____ _____

(Staff Signature) (Date/Time)

Diabetes Care Management Pilot Project Performance Measurement

PECS Data Dictionary
Key Variables

Demographic Data		
Variable	**Definition/Range of Responses**	
Zip Code of Residency/ Primary Location	Zip code in which patient lives or, if homeless, where he or she reports to stay most regularly	
Date of Birth	Date of Birth	
Ethnicity/Race	*Enter only one for each patient*	Choose the appropriate ethnicity/race in PECS registry based on what patient indicated.
Gender	Female or Male	
Homeless	Doubled Up Not Homeless Other Homeless Shelter or Transitional Street Unknown	

Encounters	
Variable	**Definition/Range of Responses**
Office Visit	Face to face meeting between a patient and a physician, mid-level provider, LVN, RN, health educator, or case manager for any duration.
Telephone Interview/Communication	Voice to voice discussion between a patient and a physician, mid-level provider, LVN, RN, health educator or case manager for any duration, and initiated by either party.
Group Visit	Patient participation in a scheduled educational session facilitated by a physician, mid-level provider, LVN, RN, health educator, or case manager.

Vitals	
Variable	**Definition/Range of Responses**
Height	Reported Height inches
Weight	Reported Weight pounds
Body Mass Index	Calculated after height and weight entered
Systolic Blood Pressure	Measured Systolic Blood Pressure
Diastolic Blood Pressure	Measured Diastolic Blood Pressure

Chronic Conditions	
Variable	**Definition/Range of Responses**
Diabetes Type 2	Diagnosed: Yes or No
Retinopathy	Diagnosed: Yes or No
Congestive Heart Failure	Diagnosed: Yes or No
Cerebrovascular Disease	Diagnosed: Yes or No
Neuropathy	Diagnosed: Yes or No
Depression	Diagnosed: Yes or No
Chronic Renal Insufficiency	Diagnosed: Yes or No
Hypertension	Diagnosed: Yes or No
Coronary Artery Disease	Diagnosed: Yes or No
Dyslipidemia	Diagnosed: Yes or No
Obesity	Diagnosed: Yes or No
Insomnia	Diagnosed: Yes or No
Anxiety	Diagnosed: Yes or No
Dual Diagnosis	Diagnosed: Yes or No
Medications	
Variable	**Medication Prescribed**
ACE Inhibitor	Yes/No/Contraindicated/Declines
AG Inhibitor	Yes/No/Contraindicated/Declines
Antiplatelet/Antithrombotic	Yes/No/Contraindicated/Declines
ARB	Yes/No/Contraindicated/Declines
Biguanides	Yes/No/Contraindicated/Declines
Glitinides	Yes/No/Contraindicated/Declines
Insulin	Yes/No/Contraindicated/Declines
Statins	Yes/No/Contraindicated/Declines
Sulfonylurea	Yes/No/Contraindicated/Declines
TZD/Glitazones	Yes/No/Contraindicated/Declines

Laboratory Test Results	
Variable	**Definition/Range of Responses**
ALT	Reported Lab Value
AST	Reported Lab Value
Cholesterol	Reported Lab Value
LDL	Reported Lab Value
Triglycerides	Reported Lab Value
Creatinine	Reported Lab Value
HDL	Reported Lab Value
Hemoglobin A1c	Reported Lab Value
Microalbumin/Creatinine Ratio	Reported Lab Value
Vaccinations and Immunizations	
Variable	**Definition/Range of Responses**
Flu Vaccine	Vaccinated: Yes or No
Pneumococcal Vaccine	Vaccinated: Yes or No
Consults and Education	
Variable	**Date**
Foot Exam with Microfilament	Date of Each Exam

EXHIBIT ____ ATTACHMENT V

PUBLIC-PRIVATE PARTNERSHIP PROGRAM
APPROVED PILOT PROJECT FACILTY SITES

CONTRACT AGENCY NAME

SITE NUMBER	SITE ADDRESS

Chronic Care Model Assessment

This Chronic Care Model Assessment is designed to help systems and provider practices move toward the "state-of-the-art" in the general management of chronic illness. The results can be used to help your team identify areas for improvement. Please complete this assessment as follows:

1. Answer each question from the perspective of the physical site (e.g., the practice, clinic, hospital) and system which supports care for your pilot team population of focus.

2. Return one completed Assessment form from your team. [Note: If your population of focus is drawn from more than one physical site (three separate clinics, for example), please return one Assessment form for *each* physical site.]

3. For each row, circle the point value that best describes the level of care currently supporting your study population. The rows in this form present the key aspects of chronic illness care. Each aspect is divided into levels showing various stages in improving chronic illness care. The stages are represented by points which range from 1 to 12. The higher point values in the levels indicate that the actions described in that box have been more fully implemented.

4. Sum the points circled for each section, calculate the average score, and enter these scores in the space provided at the end of each section. Then sum all section scores and compute the average score for the program as a whole by dividing the sum by 21. Please enter these Overall Total Program Score (sum of all scores) and Average Program Score (Total Program Score/21) in the spaces provided.

For more information, please contact The W.A. (Sandy) MacColl Institute for Healthcare Innovation.
The contact information is:

Improving Chronic Illness Care: A National Program of The Robert Wood Johnson Foundation

W.A. (Sandy) MacColl Institute for Healthcare Innovation Phone: 206-287-2704
Center for Health Studies Fax: 206-287-2138 Email: austin.b@ghc.org
Group Health Cooperative of Puget Sound 1730 Minor Avenue, Suite 1290 Seattle, WA 98101-1448

Organization Name _____

Part 1: **Organization of the Healthcare Delivery System.** Chronic illness management programs may be more effective if the overall system (organization) in which care is provided is oriented and led in a manner that allows for a focus on chronic illness care. The characteristics of an organization include: leadership, goals, improvement strategies, incentives and regulations that are oriented toward chronic illness management.

Components	Level D	Level C	Level B	Level A
Overall Organizational Leadership in Chronic Illness Care SCORE	...does not exist or there is a little interest. 1 2 3	...is reflected in vision statements and business plans, but no resources are specifically earmarked to execute the work. 4 5 6	...is reflected by senior leadership and specific dedicated resources (dollars and personnel). 7 8 9	...is part of the system's long term planning strategy, receive necessary resources, and specific people are held accountable. 10 11 12
Organizational Goals for Chronic Care SCORE	...do not exist or are limited to one condition 1 2 3	...exist but are not actively reviewed. 4 5 6	...are measurable and reviewed. 7 8 9	...are measurable, reviewed routinely, and are incorporated into plans for improvement. 10 11 12
Improvement Strategy for Chronic Illness Care SCORE	...is ad hoc and not organized or supported consistently. 1 2 3	...utilizes ad hoc approaches for targeted problems as they emerge. 4 5 6	...utilizes a proven improvement strategy for targeted problems. 7 8 9	...includes a proven improvement strategy and uses it proactively in meeting organizational goals. 10 11 12
Incentives and Regulations for Chronic Illness Care SCORE	...are not used to influence clinical performance goals. 1 2 3	...are used to influence utilization and costs of chronic illness care. 4 5 6	...are used to support patient care goals. 7 8 9	...are used to motivate and empower providers to support patient care goals. 10 11 12
Senior Leaders SCORE	...discourage enrollment of the chronically ill. 1 2 3	...do not make improvements to chronic illness care a priority. 4 5 6	...encourage improvement efforts in chronic care. 7 8 9	...visibly participate in improvement efforts in chronic care. 10 11 12

Total Part 1 Score _____ **Average Part 1 Score (Total Part 1 Score/5)** _____

Part 2: Community Linkages. Linkages between the health delivery system (or provider practice) and community resources may play important roles in the management of chronic illness.

Components	Level D	Level C	Level B	Level A
Linking Patients to Outside Resources	...is not done systematically.	... is limited to a list of identified community resources in an accessible format.	...is accomplished through a designated staff person or resource responsible for ensuring providers and patients make maximum use of community resources.	...is accomplished through active coordination between the health system, community service agencies and patients.
SCORE	1 2 3	4 5 6	7 8 9	10 11 12

Total Part 2 Score (also equals Average Part 2 Score) _____

Part 3: Practice Level. Several components that manifest themselves at the level of the individual provider practice (e.g. individual clinic) have been shown to improve chronic illness care. These characteristics fall into general areas of self-management support, delivery system design issues that directly affect the practice, decision support, and clinical information systems.

Part 3: Self-Management Support. Effective self-management support can help patients and families cope with the challenges of living with and treating chronic illness and reduce complications and symptoms.

Components	Level D	Level C	Level B	Level A
Assessment and Documentation of Self-Management Needs and Activities	...are not done.	...are expected.	...are completed in a standardized manner.	...are regularly assessed and recorded in standardized form linked to a treatment plan available to practice and patients.
SCORE	1 2 3	4 5 6	7 8 9	10 11 12
Self-Management Support	...is limited to the distribution of information (pamphlets, booklets).	...is available by referral to self-management classes or educators.	...is provided by trained clinical educators who are designated to do self-management support, affiliated with each practice, and see patients on referral.	...is provided by clinical educators affiliated with each practice, trained in patient empowerment and problem-solving methodologies, and see most patients with chronic illness.
SCORE	1 2 3	4 5 6	7 8 9	10 11 12
Addressing Concerns of Patients and Families	...is not consistently done.	...is provided for specific patients and families through referral.	...is encouraged, and peer support, groups, and mentoring programs are available.	...is an integral part of care and includes systematic assessment and routine involvement in peer support, groups or mentoring programs.
SCORE	1 2 3	4 5 6	7 8 9	10 11 12

Total Self-Management Score _____ Average Self-Management Score (Total Self-Management Score/3) _____

Part 3: Subsection-Decision Support. Effective chronic illness management programs assure that providers have access to evidence-based information necessary to care for patients -- decision support. This includes evidence-based practice guidelines or protocols, specialty consultation, provider education, and activating patients to make provider teams aware of effective therapies.

Components	Level D	Level C	Level B	Level A
Evidence-Based Guidelines	...are not available.	...are available but are not integrated into care delivery.	...are available and supported by provider education.	...are available, supported by provider education and integrated into care through reminders and other proven provider behavior change methods.
SCORE	1 2 3	4 5 6	7 8 9	10 11 12
Involvement of Specialists in Improving Primary Care	...is primarily through traditional referral.	...is achieved through specialist leadership to enhance the capacity of the overall system to routinely implement guidelines.	...includes specialist leadership and designated specialists who provide primary care team training.	...includes specialist leadership and specialist involvement in improving the care of primary care patients.
SCORE	1 2 3	4 5 6	7 8 9	10 11 12
Provider Education for Chronic Illness Care	...is provided sporadically.	...is provided systematically through traditional methods.	...is provided using optimal methods (e.g. academic detailing).	...includes training all practice teams in chronic illness care methods such as population-based management, and self-management support.
SCORE	1 2 3	4 5 6	7 8 9	10 11 12
Informing Patients about Guidelines	...is not done.	...happens on request or through system publications.	...is done through specific patient education materials for each guideline.	...includes specific materials developed for patients which describe their role in achieving guideline adherence.
SCORE	1 2 3	4 5 6	7 8 9	10 11 12

Total Decision Support Score _____ Average Decision Support Score (Total Decision Support Score/4) _____

Part 3: Subsection-Delivery System Design. The available evidence suggests that effective chronic illness management involves more than simply adding additional interventions to a current system focused on acute care. It may necessitate changes to the organization of practice that directly impact the day-to-day provision of care.

Components	Level D	Level C	Level B	Level A
Practice Team Functioning	...is not addressed.	...is addressed by assuring the availability of individuals with appropriate training in key elements of chronic illness care.	...is assured by regular team meetings to address guidelines, roles and accountability, and problems in chronic illness care.	...is assured by teams who meet regularly and have clearly defined roles including patient self-management education, proactive follow-up, and resource coordination and other skills in chronic illness care.
SCORE	1 2 3	4 5 6	7 8 9	10 11 12
Practice Team Leadership	...is not recognized locally or by the system.	...is assured by the organization to reside in specific organizational roles.	...is assured by the appointment of a team leader but the role in chronic illness is not defined.	...is guaranteed by the appointment of a team leader who assures that roles and responsibilities for chronic illness care are clearly defined.
SCORE	1 2 3	4 5 6	7 8 9	10 11 12
Appointment System	...can be used to schedule acute care visits, follow-up and preventive visits.	...assures scheduled follow-up with chronically ill patients.	...are flexible and can accommodate innovations such as customized visit length or group visits.	...includes organization of care that facilitates the patient seeing multiple providers in a single visit.
SCORE	1 2 3	4 5 6	7 8 9	10 11 12
Follow-up	...is scheduled by patients or providers in an ad hoc fashion.	...is scheduled by the practice in accordance with guidelines.	...is assured by the practice team by monitoring patient utilization.	...is customized to patient needs, varies in intensity and methodology (phone, in person, email) and assures guideline follow-up.
SCORE	1 2 3	4 5 6	7 8 9	10 11 12

Total Delivery System Design Score _____

Average Delivery System Design Score (Total Delivery System Design Score/4) _____

Part 3: Subsection-Clinical Information System. Timely, useful information about individual patients and populations of patients with chronic conditions is critical feature of effective programs, especially those that employ population-based approaches. [7, 8]

Components	Level D	Level C	Level B	Level A
Registry (list of patients with specific conditions)	...is not available.	...includes name, diagnosis, contact information and date of last contact either on paper or in a computer database.	...allows queries to sort sub-populations by clinical priorities.	...is tied to guidelines which provide prompt and reminders about needed services.
SCORE	1 2 3	4 5 6	7 8 9	10 11 12
Reminders to Providers	...are not available.	...include general notification of the existence of a chronic illness, but does not describe needed services at time of encounter.	...includes indications of needed service for populations of patients through periodic reporting.	...includes specific information for the team about guideline adherence at the time of individual patient encounters.
SCORE	1 2 3	4 5 6	7 8 9	10 11 12
Feedback	...is not available or is non-specific to the team.	...is provided at infrequent intervals and is delivered impersonally.	...occurs at frequent enough intervals to monitor performance and is specific to the team's population.	...is timely, specific to the team, routine and personally delivered by a respected opinion leader to improve team performance.
SCORE	1 2 3	4 5 6	7 8 9	10 11 12
Patient Treatment Plans	...are not expected.	...are achieved through a standardized approach.	...are established collaboratively and include self management as well as clinical goals.	...are established collaborative and include self management as well as clinical management. Follow-up occurs and guides care at every point of service.
SCORE	1 2 3	4 5 6	7 8 9	10 11 12

Total Clinical Information System Score _____

Average Clinical Information System Score (Total Clinical IS Score/4) _____

Who provided information for completing this Assessment?
Name(s) Title(s)

Briefly describe the process you used to fill out the form (e.g., reached consensus in a face-to-face meeting; filled out by the team leader in consultation with other team members as needed; each team member filled out a separate form and the responses were averaged).

Chronic Care Model Assessment Scoring Summary (bring forward scoring at end of each section to this page)

Total Org. of Health Care System Score (page 2) _____

Total Community Linkages Score (page 3) _____

Total Self-Management Score (page 3) _____

Total Decision Support Score (page 4) _____

Total Delivery System Design Score (page 5) _____

Total Clinical Information System Score (page 6) _____

Overall Total Program Score (sum of all scores) _____

Average Program Score (Total Program Score/ 21) _____

What Does it Mean?

The overall average score provides an indication of the state of your organization's structures and processes supportive of good chronic illness care. It ranges from limited support to fully developed support of good chronic illness care. Average scores for individual parts and sub-sections can help you identify areas which your organization may wish to improve. You can contact the MacColl Institute for Healthcare Innovation for more assistance in interpreting the results. The levels are:

Average Score between 1 and 3 = Limited Support of Good Chronic Illness Care
Average Score between 4 and 6 = Basic Support of Good Chronic Illness Care
Average Score between 7 and 9 = Excellent Support of Good Chronic Illness Care
Average Score between 10 and 12 = Fully Developed Support of Good Chronic Illness Care

References

VonKorff, M., Gruman, J., Schaefer, J.K., Curry, S.J., & Wagner, E.H. (1997). Collaborative management of chronic illness. Annals of Internal Medicine, 127. 1097-1102.

McCulloch, D.M., et al. Implementation of a Comprehensive Program to Promote a Population-Based Approach to Diabetes Management In a Primary Care Setting: Early Results and Lessons Learned. (1998) Effective Clinical Practice. 1:12-22.

Katon, W., Von Korff, M., Lin, E., Walker, E., Simon, G.E., Bush, T., Robinson, P., & Russo, J. (1995). Collaborative management to achieve treatment guidelines. JAMA, 273. 1026-1031.

Wagner, E.H., Austin, B.T., & Von Korff, M. (1996). Improving outcomes in chronic illness. Managed Care Quarterly, 4. (2) 12-25.

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Calkins, E., Boult, C., Wagner, E.H., & Pacala J. (1998). New Ways to Care for Older People: Building Systems Based on evidence. Springer.

Greenlick, M.R. (1995). The emergence of population-based medicine. HMO Practice, 9. 120-122.

Wagner, E.H. (1995). Population-based management of diabetes care. Patient Education and Counseling, 16. 225-230

EXHIBIT II

Contract # _____

PUBLIC/PRIVATE PARTNERSHIP PROGRAM
HEALTH CARE SERVICES AGREEMENT
(_____ Partner Facility Sites)

AMENDMENT NO. ___

THIS AMENDMENT is made and entered into this _____ day of _____, 2007,

by and between COUNTY OF LOS ANGELES (hereafter "County"),

and _____ (hereafter "Contractor").

WHEREAS, reference is made to that certain document entitled "PUBLIC/PRIVATE PARTNERSHIP PROGRAM HEALTH CARE SERVICES AGREEMENT", dated _____, further identified as Agreement No. _____ and any Amendments thereto (all hereafter "Agreement"); and

WHEREAS, the Agreement provides that changes to its terms may be made in the form of a written amendment which is formally approved and executed by the parties.

WHEREAS, it is the intent of the parties hereto to amend the Agreement to extend the term for Public/Private Partnership Program Health Care Services scheduled to expire on June 30, 2007, for three (3) months, on a month-to-month basis, through

September 30, 2007, under the same terms and conditions, and make the changes described hereinafter.

NOW, THEREFORE, the parties hereby agree as follows:

1. This Amendment shall be effective upon its approval by County's Board of Supervisors.

2. This Amendment extends the term of the Agreement for three (3) months, on a month-to-month basis, beginning July 1, 2007 through September 30, 2007, under the same terms and conditions.

3. Agreement, Paragraph 2, MAXIMUM OBLIGATION, Subparagraph D, shall be added as follows:

"2. MAXIMUM OBLIGATION:

"D. County's reimbursement to Contractor for the period of July 1, 2007 through September 30, 2007 shall not exceed _____ Dollars ($_____). That portion of the maximum obligation shall be _____ Dollars ($_____) for the provision of primary care services; and _____ Dollars ($_____) for the provision of dental care services; and _____ Dollars ($_____) for the provision of specialty care services."

4. Except for the changes set forth hereinabove, Agreement shall not be changed in any other respect by this Amendment.

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Agreement to be subscribed by its Director of Health Services, and Contractor has caused this Agreement to be subscribed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By _____

Bruce A. Chernof, M.D.
Director and Chief Medical Officer

_____
Contractor

By _____
Signature

_____
Printed Name

Title _____

(AFFIX CORPORATE SEAL)

APPROVED AS TO FORM
BY THE OFFICE OF THE COUNTY COUNSEL

APPROVED AS TO CONTRACT
ADMINISTRATION:

Department of Health Services

By _____
Cara O'Neill, Chief
Contracts and Grants Division

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